TX_Fee_IPH.OPH.BHI_New_20210901-20220831 (CHIRP)
Round 3 Question Set
July 8, 2021

SECTION I: DATE AND TIMING INFORMATION

1. Preprint Question 4:
    a. Please describe what is leading to the significant increase in total dollar amounts for this directed payment compared to previous UHRIP proposals, and why these additional funds are necessary.

    State Response: Texas hosted a workgroup in the Fall of 2020 to continue efforts to reform the UHRIP program and incorporate aspects of the DSRIP transition. Through the DSRIP program, hospitals were estimated to receive payments of approximately $2.1 billion associated with various quality improvements in DY10. The DY10 UHRIP estimates were $2.67 billion. The proposed program size for the rate period for the Comprehensive Hospital Increase Reimbursement Program (CHIRP) substantially overlaps with DY11 and the program is intended to serve as a continuation of the prior UHRIP program with an expansion to incorporate the financial and quality benefits of the DSRIP program that will be ending. The proposed program value of $5,020,000,000 for state fiscal year 2022is intended to sustain the existing program size, plus the value of the DSRIP DY10 for hospitals, with increased administrative expenses for Medicaid managed care organizations who will be working with providers to continue the quality improvements that have been incorporated into the program. It is important to note that the $5,020,000,000 size is an estimate based upon forecasted caseloads and forecasted hospital utilization. Actual payments to MCOs could vary based upon caseload fluctuations, and payments to hospitals by MCOs could vary based upon actual utilization during the rating period.

    b. Please clarify if the estimated total dollar amount provided in response to question 4 includes any allowance for administration, profit margin, or premium tax.

    State Response: Yes, the estimated total dollar amount of $5.02 billion includes all estimated capitation rate costs, including administration, risk margin, and premium tax.

    c. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:
        i. Component 1 (UHRIP)
        ii. Component 2 (ACIA)
        iii. Administration, profit margin, or premium tax.

    State Response: Please see the "Total Dollars" tab in Attachment 1. Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

2. Overarching question: The structure of this payment arrangement is complex. It also seems prone to creating perverse incentives for the plans. For example, the required uniform increases could result in plans negotiating lower base rates with providers subject to the state directed payment.

a. Has the state instituted any measures to counteract any such perverse incentives?

State Response: While not specific to the former UHRIP or proposed CHIRP, the Medicaid managed care contracts and the Texas Government Code § 533.005(a)(25), prohibit an MCO from implementing "…significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless: (1) it receives HHSC's prior approval, or (2) the reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. For purposes of this requirement an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers."

The state has not received any formal provider or MCO complaints that contract negotiations have been impeded as a direct response to the prior or proposed pre-print. HHSC will continue to monitor contract compliance, network adequacy, and complaints registered by both members and providers. The state will investigate any concerns that appear to be related to the CHIRP.

b. Has the state monitored rates paid by plans (e.g. through encounter data submissions) to monitor if the negotiated rates paid by plans have decreased since UHRIP has been implemented?

State Response: No. The state has not undertaken a study to determine whether payment-to-charge ratios have changed since implementation of the UHRIP/CHIRP program. However, since the inception of the UHRIP program, there have been additional appropriations to support rate increases for rural and children's hospitals, so it might be difficult to perform such a study. In discussions with external stakeholders and Medicaid managed care organizations, no participants have raised concerns about widespread modifications to base reimbursement rates agreed to in the underlying in-network contracts between MCOs and providers because of the program.

CMS Round 2 Question:

How does the state monitor that the plans are complying with the contract provisions to pay these uniform increases?

State Round 2 Response: The state has established contact compliance mechanisms to ensure compliance with all terms in the Medicaid managed care organization contracts, including provisions and requirements related to directed-payment programs. If HHSC identifies non-compliance, e.g. from provider complaints, HHSC will address the non-compliance with the MCO. This can be done through a variety of methods, including providing technical assistance, implementing corrective action plans, or assessing liquidated damages. If a provider does not believe that an MCO is operating in compliance with the program requirements, Medicaid managed care providers can submit complaints and inquiries directly to HHSC Managed Care Compliance and Operations (MCCO). If the complaint is an MCO related issue, a notification letter

detailing the issue and providing a due date for response will be sent to the MCO involved with the complaint. Once the MCO responds, HHSC staff will review and determine if all concerns were sufficiently addressed; if not, the specialist will continue researching and communicating with all parties until complete resolution is achieved.

c. If the state's goal is to increase hospital reimbursement up to a certain level, has the state considered requiring plans to implement a minimum fee schedule (or series of minimum fee schedules) instead of uniform increases?

State Response: The goal of CHIRP is to incentivize hospitals to improve in the quality goals and objectives targeted by the program.

In response to legislative direction, the state has implemented a minimum fee schedule for rural hospitals in accordance with state law that requires a minimum fee schedule as it was believed that these financially vulnerable hospitals could use support in their negotiations with MCOs; however, those actions were not related to the implementation of UHRIP/CHIRP, but were in response to legislative direction to provide additional support to rural hospitals who might be at risk of closures.

Additionally, as the program incorporates additional performance modules and measures, it is important that the program is an "opt-in" and we do not anticipate that a minimum fee schedule would be able to provide the same flexibility that a uniform rate increase does with respect to providers' optional participation in the program components.

3. Preprint Question 8:
   a. Please further describe the methodology used to calculate the ACIA payment increase. In the response, please clarify if the calculation is performed separately for each hospital, or if it is performed for the entire class. As part of the response, please clarify if it is ever possible for the provider reimbursement to exceed the ACR for any specific provider.

State Response: The ACIA rate increase percentage is calculated separately for inpatient and outpatient services at the individual hospital level. The inpatient ACIA increase is determined using a uniform percentage of the inpatient ACR gap. The ACR gap is calculated using the inpatient payment-to-charge ratio of commercial insurance multiplied by the inpatient Medicaid charges, minus inpatient Medicaid payments. If the hospital has a positive ACR gap (i.e., the provider is estimated to receive more from a commercial payor than it received from Medicaid), the inpatient ACIA payment is a uniform percentage of the individual hospital's ACR gap, less the estimated payments received from the UHRIP component. If the inpatient UHRIP payment is greater than the ACR gap, the provider will receive a 0% ACIA rate. All of the steps listed above are identical for the calculation of outpatient ACIA, where outpatient values are used in place of the inpatient values.

It is never possible for a provider participating in ACIA to receive reimbursement that exceeds ACR.

CMS Round 2 Question:

1. Please update the preprint with the additional information provided above.

   State Round 2 Response: The additional information has been added to the state's response to preprint question 8 (please see revised Attachment B).

   CMS Round 3 Question: The state above indicates that "the inpatient/outpatient ACIA increase is determined using a uniform percentage of the inpatient/outpatient ACR gap". Can the state please clarify if the reference to "70% of ACR before Cutback" in column R within tab "CHIRP Payment Calc" of Attachment C is this "uniform percentage"?

   State Round 3 Response: Yes, it is.

2. From the state's response, we understand that a provider could have a 0% ACIA increase but have an inpatient URHIP increase that could potentially result in payment that is over the ACR. Is this correct? Yes.
   a. If yes, would these providers not participate in ACIA and therefore not need to report on the ACIA quality measures? Correct, these providers are viewed as non-participants in ACIA and therefore do not need to report on the ACIA quality measures.

      CMS Round 3 Question: Why does the state believe it is appropriate that providers can receive reimbursement that exceeds the ACR under UHRIP (without reporting or satisfying the additional quality measures that providers participating in ACIA will need to do), but providers will not be able to receive reimbursement that exceeds the ACR under ACIA?

      State Round 3 Response: UHRIP and ACIA are distinct program components that confer to participants separate percentage rate increases. A provider can participate in UHRIP and not ACIA, as ACIA is considered a voluntary component. While some providers are precluded from receiving a rate increase under ACIA because the sum of their base payment, plus the UHRIP component payment result in a rate increase wherein that provider has no estimated ACR Gap, the provider is in fact not participating in ACIA and should not be required to provide reporting related to that component.

   b. The state notes that there are now 166 individual facilities that are reported as 0% for ACIA. How many of these hospitals would fall into the category of having a UHRIP percentage increase that exceeds the ACR? The most recent

calculation shows 115 hospitals requesting participation in ACIA as having 0% for ACIA. Of those, 31 hospitals have a UHRIP rate greater than ACR. In the Attachment C, tab "CHIRP Payment Calc", those hospitals can be viewed by filtering on columns Y, AC, AD, and BE.

CMS Round 3 Question:

i. In looking at tab "CHIRP Payment Calc" in Attachment C and filtering columns, Y, AC, and AD, we believe there are 96 hospitals (vs 115) that requested participation in ACIA but have a 0% for ACIA. Can the state please clarify?

State Round 3 Response: We have corrected the #n/a error showing up for some providers in column Y, and that results in 98 providers requesting to participate in ACIA but having 0%.

ii. Besides having a UHRIP rate greater than ACR, what are the reasons for the rest of the 96 (or 115 hospitals) having a 0% for ACIA?

State Round 3 Response: Some providers did not have commercial data for the time period that was requested, either due to a change of ownership or due to being a new facility.

b. Please affirm that the payments required under this payment arrangement will only be made for Medicaid services on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2022 rating period only, and that the payments will not be made on behalf of individuals who are uninsured, covered for such services by another insurer (e.g. Medicare), nor Medicaid services provided through the state's fee-for-service program.

State Response: Texas affirms only in-network Medicaid managed care encounters for the SFY 2022 rating period are eligible for the rate increase.

4. Preprint Question 19b:
   a. Please provide an exhibit showing the average increase for each class for each service in each SDA separately for the mandatory and optional payments and in total.

State Response: State Response: Please see the "Avg Increase by SDA and Class" tab in Attachment 1 for the requested exhibit. Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program.

CMS Round 2 Response: We note that the providers in the MRSA Northeast Non-State-Owned IMD, Harris State-Owned IMD, and MRSA Central State-Owned IMD classes are not participating in UHRIP nor ACIA. Can the state please explain why?

State Round 2 Response: No applications for enrollment were received for the providers of these class and SDA combinations.

b. Please clarify if the increases for each class, SDA, and component will differ between inpatient and outpatient services. If so, CMS requests the state also provide the exhibit requested above for both inpatient and outpatient services separately.

State Response: Yes, rate increases for each class, SDA, and component will differ between inpatient and outpatient services. Please see "Avg Increase by SDA and Class" tab in Attachment 1 for the requested exhibit.

c. Per the "Q19b CHIRP Rate Increases" tab in Attachment C:
   i. Please explain why the minimum increase for each component of the CHIRP increase for Children's Hospitals is 0% but the total minimum is 19%.

State Response: The modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Question 19b" tab of Attachment 1. The new numbers are as follows: for children's inpatient services, the minimum UHRIP rate is 0%, the minimum ACIA rate is 0%, but the total minimum CHIRP rate is 46%. This data is based on the values presented in the "Revised Q21 Hospital Rates" tab of Attachment 1. NPI 1447355771 Seton Healthcare -Dell Children's Medical Center received a 0% UHRIP rate along with NPI 1437171568 Methodists Childrens Hospital - Covenant Childrens Hospital. However, both of these providers have an ACIA rate, so they do not end up with a 0% inpatient CHIRP rate. NPI 1720480627 Children's Medical Center of Dallas - Children's Medical Center Plano received a 57% inpatient UHRIP rate, but a 0% inpatient ACIA rate, causing the minimum ACIA rate to be 0%. The total minimum rate for inpatient CHIRP Children's hospitals is actually for NPI 1558659714 El Paso Childrens Hospital.

Texas has previously noted that Medicare rates are generally developed with an elderly population, whereas Children's hospitals may have increased costs (and therefore higher negotiated commercial rates) that reflect the specialty care and services that are being provided for pediatric services.

   ii. Please explain why the maximum CHIRP percentage increase for state owned non-IMD hospitals is 2325% and for urban hospitals it is 3684%.

State Response: The modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Question 19b" tab of Attachment 1. The maximum CHIRP rate increase for state-owned non-IMD hospitals is 193% for inpatient services and 192% for outpatient services. The maximum CHIRP rate increase for urban hospitals is 1116% for inpatient services and 2340% for outpatient services. The 2340% increase was based on NPI 1609855139 Baylor Heart and Vascular Center, which reported a very high payment-to-charge ratio

for commercial insurers and received a UHRIP rate of 37% and an ACIA rate of 2304%. This hospital only had $8,320 of eligible encounters based on the preliminary data, and its outpatient ACIA dollars is $191,665, so its ACIA rate is $191,665 divided by $8,320 which is 2304%.

These types of variations in provider's ACR data are likely attributed to many varying factors, but Texas believes the Medicaid program is justified in establishing a reimbursement rate that is competitive with other payors in Texas.

CMS Round 2 Question: Data appears to be limited for some providers with very low volume. Since this data is used to establish the UHRIP and particularly the ACIA uniform increase percentages, has the state considered the credibility of the data for providers with very high uniform increase percentages? Does the state have plans to conduct any audits on the ACR data provided?

State Round 2 Response: The volume of services delivered by a provider is not a measure by which the state examines the veracity of information provided. All hospitals, including those with low volume, are required to maintain all supporting documentation at the hospital for any information provided for the calculation of the ACR gap for a period of no less than 5 years from the date of the application. Providers must also certify that any information provided may be published at the provider level in future reports, audits, or public information requests. The state does not currently plan to conduct audits specifically focused on the information provided in the CHIRP application, however, providers are subject to oversight by the state's Office of Inspector General. If at any point the state discovers that a provider misrepresented the data submitted in the CHIRP application, the provider would be subject to all possible legal and financial remedies, including recoupment of all funds.

CMS Round 3 Question: We would strongly recommend that the state consider implementing some form of monitoring or audit to investigate outliers in CHIRP data that is self-reported to the state by the providers.

State Round 3 Response: Acknowledged. The state may request technical assistance from CMS on the implementation of monitoring efforts that would be satisfactory to CMS.

iii. Please explain why the maximum CHIRP percentage increase for state owned non-IMD hospitals is the same as the maximum URHIP percent increase (i.e., 2325%), when the maximum ACIA percent increase is 184%.

State Response: The modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Question 19b" tab of Attachment 1.

The maximum inpatient CHIRP increase is 193% and the maximum inpatient UHRIP increase is 96%. This data is based on the values presented in the "Revised Q21 Hospital Rates" tab of Attachment 1.

5. Preprint Question 19d:
    a. The state indicates that the total value of the UHRIP component will be equal to the percentage of the estimated Medicare gap on a per class basis. Can the state explain what is meant by total value? Does this mean the total dollars for all the UHRIP payments made to all hospitals eligible will be equal to the sum of the Medicare gap for each provider class? Additionally, does this mean the Medicare gap is calculated per class across SDAs? Or is the Medicare gap calculated by class within an SDA and then summed across SDAs?

    State Response: The total value of the UHRIP component means the total estimated payments for UHRIP. The total dollars in the UHRIP component are equal to a percentage of the Medicare UPL gap not to exceed 100%. This percentage is determined at an SDA and class level. The Medicare gap is calculated separately for inpatient and outpatient services and is aggregated by SDA and class. For example: if the inpatient Medicare gap for a class and SDA totaled $1 million and the percentage of the Medicare gap was set to 100%, the total inpatient UHRIP value would be set to $1 million. If the class and SDA had $5 million in estimated inpatient encounters, the inpatient rate would be 20% ($1 million divided by $5 million). The intention of the state is to ensure that UHRIP incentivizes providers to advance certain quality goals and objectives by increasing payments to approximately what Medicare would have paid on the same encounters, aggregated for the class in the SDA.

    CMS Round 2 Response: Please add this additional detail to the preprint.

    State Round 2 Response: The additional information has been added to the state's response to preprint question 19d, which is included in new Attachment K.

    b. The state indicates that the allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA. Can the state please explain what this means? The allocation methodology seems to differ from the methodology used to develop the total value. Please explain the differences and the state's rationale.

    State Response: The UHRIP component will be calculated on an SDA and class basis for IP and OP services. The percentage of the Medicare gap (not to exceed 100%) will be assigned at the SDA level. Therefore, the Medicare gap in each class and SDA combination will be proportional to the SDA. In the examples provided in the preprint, the Medicare gap was set at 100% for all SDAs.

    CMS Round 2 Questions:

1. In the state's June submission, please provide CMS the final, assigned Medicare gap percentage for each SDA, for inpatient and outpatient services.

   State Round 2 Response: Attachment C now has an added "UPL Summary" summary tab that lists the UPL percentages by SDA, inpatient and outpatient services.

   CMS Round 3 Questions: Can the state please provide a brief description of what each column in the table represent?

   State Round 3 Response: Attachment C has been updated, and the "Summary" tab details the Medicare UPL gaps by SDA/class and Inpatient/Outpatient in columns B and C.

2. CMS's understanding from review of the actuarial certification for the STAR program is that there are some related party arrangements in some SDAs. In the rate certification, the state and the actuary apply adjustments to the base data used for capitation rate setting to ensure that any such payments do not inflate the capitation rates. Is the state concerned that some of the data provided by facilities, including ACR data, have been inflated as a result of related party arrangements? Has the state investigated any potential related party arrangements that may be inflating the ACR or impacting the calculations of the uniform percentage increases for some providers?

   State Round 2 Response: The state has not examined which providers may also have a related-party commercial insurance plan from which they receive payments but is not concerned at this time. The ACR data collected requires them to report all commercial payments and charges, regardless of who the payer is. Because the reported information includes information from all payers, not just the top five or some other subset, the state believes that the aggregate nature of the payment-to-charge ratio calculation should dilute any such anomalies in payment, if they were to exist.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

6. Preprint Question 20:
   a. Are there any provider classes new to this preprint submission?

      State Response: Yes; the prior program periods used class definitions that did not align with the class definitions in the Texas Medicaid state plan. The class definitions used for this program period will reduce the number of distinct classes from 8 to 6.

   b. What overlap (if any) is there between provider classes and how is this accounted for in the provider payment analysis?

State Response: There is no overlap between classes.

c. Please clarify why the University of Texas Southwestern hospital is a state-owned acute care hospital, but not currently included in the definition of "State Teaching Hospital" in the state plan.

State Response: The hospital owned by UT Southwestern was originally a non-profit hospital that was purchased by UT Southwestern in 2005. Texas has not updated the state plan to reflect that the hospital owned by UT Southwestern is a state-owned teaching hospital. Texas is considering updating the state plan to reflect this in the future.

7. Preprint Question 21: The state indicates in response to preprint question 21, *"HHSC will not enroll providers or collect final data to calculate the ACR gap until April 2021, but HHSC is including an estimate of the program amounts and rate increases, based upon optional survey data that was collected to assist the state in designing the program. The state will plan to resubmit final rate increase percentages following enrollment into the program and recalculation of the rate increases using more current data. We will submit this information no later than June 10, 2021."*

Please note that CMS will not be able to approve this state directed payment proposal until we receive the final rate increase percentages.

We also understand that many of the figures provided in this submission are subject to change once the final rate increase percentages are finalized. Please clarify each figure that is subject to change as the payment arrangement is finalized, including but not limited to the estimate of the total dollar amount of the payment arrangement, the magnitude of the payment increases for each component/class/SDA/hospital, the reimbursement rate analysis, etc., and confirm that these figures will be updated with the final submission. For every value subject to change, please describe the potential magnitude of the change.

State Response: The total dollar amount of the program will not exceed $5.02 billion in the June submission. All rate increase percentages (UHRIP, ACIA, and the overall rate) could increase or decrease as our internal and external actuaries finalize the encounters that will be used in the final capitated rates for the SFY 2022 rating period. The number of providers included in the program could decrease if we are notified that anyone wishes to withdraw their application between now and when capitated rates are finalized. The state's response to question 8 indicates the total number of providers enrolled.

HHSC must also wait to determine if there are any statutory changes, including changes that could impact reimbursement rates or payments, that result from the Texas Legislature, which is currently in session.

These figures will be updated in the final submission. In addition, after the June submission, total dollar amounts could increase or decrease again since the encounters used are estimated.

However, we do not anticipate that any changes would be significant, as typically the final values have been substantially similar to the preliminary values.

CMS Round 2 Question: Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final rate increases in June, please update the reimbursement rate analysis. Since the ACIA percent increases are calculated at a provider-specific level, we request that the reimbursement level analysis be at a provider-specific level, in addition to the summary level information that the state has provided to-date.

State Round 2 Response: Please see the final rate increases and updated reimbursement rate analysis in Attachment C.

CMS Round 3 Question: The 'Q23 Payment Levels' tab in Attachment C seems to imply that the CHIRP will result in total reimbursement that exceeds ACR on a class level (not just individual hospital level). Is this an accurate conclusion?

State Round 3 Response: No, this is not an accurate conclusion. Please see the revised Attachment C, which has the payment levels divided into 6 tabs – Q23_IP UHRIP Payment Levels, Q23_OP UHRIP Payment Levels, Q23_IP ACIA Payment Levels, Q23_OP ACIA Payment Levels, Q23_IP CHIRP Payment Levels, and Q23_OP CHIRP Payment Levels. Since the question is specifically about ACR, please look at the Q23_IP CHIRP Payment Levels and the Q23_OP CHIRP Payment Levels tabs. The highest payment level for the IP CHIRP Payment Level tab is 99%, and the highest payment level for the OP CHIRP Payment Level tab is 98%. This tab compares the ACR to the total UHRIP and ACIA payments for all providers that participated in both UHRIP and ACIA.

8. Preprint Question 21: We understand that hospitals in Texas were required to submit an enrollment application by April 5, 2021. Can the state please describe the type of response received, including hospital's interest to participate in the optional ACIA component? Specifically, how many hospitals will be participating in UHRIP and how many in ACIA?

   State Response: HHSC received 412 provider applications for CHIRP. Of those 412, 300 of the providers will be participating in the optional ACIA component.

   CMS Round 3 Question: In looking at tab "CHIRP Payment Calc" in Attachment C, can the state please clarify why there are 419 total hospitals listed since we previously understood there were 412 provider applicants?

   State Round 3 Response: The state allowed a small number of providers to submit late applications in order to participate in the program.

9. Preprint Question 21 (Attachment C): According to the information provided by the state in this excel file:

a. It appears that 551 hospitals will participate in CHIRP. Is this an accurate final count? If not, please indicate when the state will provide a final number.

State Response: 412 providers enrolled in CHIRP.

b. It appears that the table provides the percentage increase the state would require under component 1 for each individual hospital based on its provider class and SDA and then the additional percentage increase that the hospital would qualify under ACIA. Is this correct? For example, is it correct to say that the state Medicaid managed care plans would be required to pay the Parkland Memorial Hospital – Parkland Memorial – Rehab Unit (NPI 1982666111) a 170% increase from the negotiated rate as part of the UHRIP component plus an additional 2% increase from the negotiated rates as part of the ACIA component? In other words, assuming this facility met the requirements for the 2 components – the plans would be required to pay an additional increase equal to 172% of the rates negotiated by the plans and providers.

State Response: This was correct at the time of the initial submission of the pre-print. However, the modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Q21 Hospital Rates" tab of Attachment 1. The modeling has also changed to provide rates for inpatient services (IP) and outpatient services (OP). The updated percentages are as follows:

	UHRIP Rate	ACIA Rate	Total CHIRP Rate Increase
Inpatient Services	65%	42%	107%
Outpatient Services	37%	32%	69%

c. In the example above, would the 172% increase be applied to both inpatient services and outpatient services individually? If not, please indicate what the increases are for each service.

State Response: This was correct at the time of the initial submission of the pre-print. However, the modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Q21 Hospital Rates" tab of Attachment 1. The modeling has also changed to provide IP and OP rates. The total IP CHIRP rate increase would be 107% and the total OP CHIRP rate increase would be 69% for Parkland Memorial Hospital - Parkland Memorial - Rehab Unit.

d. Are the details provided in Q21 final increases or are these subject to change per the note included above? If subject to change, please note that CMS will not be able to approve this state directed payment proposal until we receive the final rate increase percentages.

State Response: The rates shown in the "Revised Q21 Hospital Rates" tab of Attachment 1 are subject to change if the encounters used in the determination of the SFY 2022 capitation rates are modified. Final rates will be communicated in June 2021.

e. In review of the data, it appears that the UHRIP increases for each class within each SDA are the same – can the state confirm this is correct? Can the state also confirm that the percentage increases included in the table below are correct?

State Response: The values have been updated in Attachment 1 based upon actual enrollment. The UHRIP rates are calculated at the SDA and class combination level for IP and OP services separately. The percent increases are subject to change based upon data updates as the capitated rates are finalized.

Provider Class	SDA	UHRIP Percentage Increase
Children's Hospital	Bexar	57%
Children's Hospital	Dallas	25%
Children's Hospital	El Paso	37%
Children's Hospital	Harris	19%
Children's Hospital	Lubbock	0%
Children's Hospital	Nueces	21%
Children's Hospital	Tarrant	14%
Children's Hospital	Travis	0%
Non-State-Owned IMD	Bexar	32%
Non-State-Owned IMD	Dallas	35%
Non-State-Owned IMD	El Paso	13%
Non-State-Owned IMD	Harris	29%
Non-State-Owned IMD	Hidalgo	16%
Non-State-Owned IMD	Lubbock	0%
Non-State-Owned IMD	MRSA Central	64%
Non-State-Owned IMD	MRSA Northeast	0%
Non-State-Owned IMD	MRSA West	30%
Non-State-Owned IMD	Tarrant	21%
Non-State-Owned IMD	Travis	49%
Rural Hospitals	Bexar	36%
Rural Hospitals	Dallas	50%
Rural Hospitals	Harris	33%
Rural Hospitals	Hidalgo	0%
Rural Hospitals	Jefferson	10%
Rural Hospitals	Lubbock	81%
Rural Hospitals	MRSA Central	13%
Rural Hospitals	MRSA Northeast	15%
Rural Hospitals	MRSA West	15%

Rural Hospitals	Nueces	21%
Rural Hospitals	Tarrant	14%
Rural Hospitals	Travis	23%
State-Owned IMD	Bexar	41%
State-Owned IMD	Dallas	283%
State-Owned IMD	El Paso	59%
State-Owned IMD	Harris	69%
State-Owned IMD	Hidalgo	58%
State-Owned IMD	MRSA Central	0%
State-Owned IMD	MRSA Northeast	0%
State-Owned IMD	MRSA West	65%
State-Owned IMD	Travis	168%
State-Owned Non-IMD	Bexar	2325%
State-Owned Non-IMD	Dallas	0%
State-Owned Non-IMD	Harris	66%
State-Owned Non-IMD	MRSA Northeast	62%
Urban	Bexar	59%
Urban	Dallas	58%
Urban	El Paso	32%
Urban	Harris	170%
Urban	Hidalgo	81%
Urban	Jefferson	126%
Urban	Lubbock	0%
Urban	MRSA Central	80%
Urban	MRSA Northeast	93%
Urban	MRSA West	65%
Urban	Nueces	49%
Urban	Tarrant	89%
Urban	Travis	65%

i. Based on the information in the table above, there are certain combinations of SDA and provider classes that it appears the state would require plans to pay percentage increases that would more than double the negotiated rate (see highlighted cells in table above). For example, it appears the state would require plans to pay an increase to 170% of the negotiated rate. This would suggest that plans are negotiating notably low rates compared to Medicare. Does the state have concerns that the plans are not meeting their network adequacy and access to care requirements under the contract?

State Response: The state is proposing these rate increases as they are supported by estimates of what Medicare or average commercial payors would have paid for the same services. The state works with our managed care organizations and providers to ensure access to care and network adequacy

requirements are met. With respect to access to care, the state notes that during the initial year that UHRIP was created, the stated goal was to support and improve access to care. The state reaffirms that this program will help support beneficiaries' access to care as it has in prior years, but with the expansion and reform of UHRIP into the CHIRP program, we will also target additional quality goals and objectives.

CMS Round 2 Question: How does the state work with the managed care organization and provider to ensure access to care? Would the state be able to share any data that supports the state's affirmation that this SDP (or UHRIP) has helped to support and improve access to care?

State Round 2 Response:

In terms of how UHRIP has helped to support and improve access to care, the goal of UHRIP is to ensure access to care by preventing decreases in network adequacy. This is the stated evaluation hypothesis in the UHRIP evaluation report (see "Hypothesis 1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.").

The *Results* section of the UHRIP Evaluation Report 2018-2019 (CHIRP reprint Attachment J) also contains information about the state's Network Adequacy contract requirements. HHSC ensures that MCOs and DMOs have adequate provider networks and provide access to care. The state tracks timeliness of care through annual surveys; monitors member and provider complaints; monitors provider terminations; analyzes geo-mapping reports to measure the distance and travel time between providers' geographic locations and members' residences; and monitors utilization of out-of-network providers.

The results of the evaluation report show that network adequacy for acute care hospital providers was maintained over time, despite the limited study period for which we have data available.

ii. In Attachment C, there is one facility – Texas DSHS TCID (NPI 1841354677) that plans would be required to pay an increase of 2325% of the negotiated rate. Can the state first confirm that this is correct and not a typo? If this is correct, this would suggest that plans are paying this facility at a rate that is just over 4% of Medicare. If this is the case, please explain how this rate is sufficient for the plans to maintain access to care requirements?

State Response: The program values have been updated based upon actual enrollment in the program and with preliminary encounter data, as shown on the "Revised Q21 Hospital Rates" tab of Attachment 1. TCID now is receiving a rate of 0%. It does not have any eligible inpatient or outpatient encounters.

CMS Round 2 Question: This seems to be a significant update; can the state provide additional details on this update and why the original data was so off?

State Round 2 Response: The original data was survey data, and the state has since received new encounter data trends and actual applications. The combination of these two elements led to many changes in the program values from those that were estimated based on the initial theoretical model.

iii. There are 8 combinations of classes and SDAs (highlighted in green above) that are reported as 0% for the UHRIP increase. Is it correct to say that these facilities are not eligible for an increase under UHRIP because they are already paid by plans at a rate that would result in no Medicare gap? Or did these facilities not apply to participate?

State Response: The modeling has been updated based upon actual enrollment in the program. The "Avg Increase by SDA and Class" tab of Attachment 1 shows 11 SDA and class combinations that have 0% inpatient UHRIP increase. The 11 combinations either did not have a positive Medicare gap or had $0 in inpatient encounters. On the outpatient side, 19 SDA and class combinations have a 0% outpatient rate increase. In addition, 3 SDA and class combinations did not have any hospitals apply for the program.

CMS Round 2 Question: Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final data in June – can the state please differentiate in some manner for the SDA and class combinations which did not have a positive Medicare gap and which had $0 in inpatient encounters?

State Round 2 Response: The SDA and class combinations that did not have a positive Medicare gap and also had $0 in inpatient encounters are as follows:

- State-Owned IMD Harris
- State-Owned IMD MRSA Central
- State-Owned IMD MRSA Northeast
- Non-State-Owned IMD MRSA Northeast

f. In review of the data, it appears that the ACIA increases for each class within each SDA vary by hospital – can the state confirm this is correct? Can the state also confirm that the percentage increase ranges included in the table below are correct?

State Response: All hospitals that participate in ACIA received a uniform percentage of the individual hospital's calculated ACR gap less payments received in UHRIP. Due to the varying levels of average commercial reimbursement at each provider, this uniform percentage of the gap results in a varied rate increase when applied to the estimated managed care encounters. The approach ensures that expenditures were directed equally, but that payments were restricted to a reasonable level.

The values have been updated based upon actual enrollment in the program. The "Avg Increase by SDA and Class" tab of Attachment 1 tab shows the new ACIA rates. They are determined separately for each hospital for inpatient and outpatient services. The rates below were correct at the time of the initial submission of the pre-print.

Provider Class	SDA	ACIA Percentage Increase
Children's Hospital	Bexar	30%
Children's Hospital	Dallas	0-52%
Children's Hospital	El Paso	54%
Children's Hospital	Harris	0-51%
Children's Hospital	Lubbock	100%
Children's Hospital	Nueces	67%
Children's Hospital	Tarrant	114%
Children's Hospital	Travis	188%
Non-State-Owned IMD	Bexar	0%
Non-State-Owned IMD	Dallas	0-115%
Non-State-Owned IMD	El Paso	0%
Non-State-Owned IMD	Harris	0-163%
Non-State-Owned IMD	Hidalgo	0%
Non-State-Owned IMD	Lubbock	0%
Non-State-Owned IMD	MRSA Central	0%
Non-State-Owned IMD	MRSA Northeast	0%
Non-State-Owned IMD	MRSA West	0-6%
Non-State-Owned IMD	Tarrant	0%
Non-State-Owned IMD	Travis	0-123%
Rural Hospitals	Bexar	0-55%
Rural Hospitals	Dallas	127%
Rural Hospitals	Harris	0%
Rural Hospitals	Hidalgo	0-60%
Rural Hospitals	Jefferson	0-87%
Rural Hospitals	Lubbock	0-193%
Rural Hospitals	MRSA Central	0-203%
Rural Hospitals	MRSA Northeast	0-60%
Rural Hospitals	MRSA West	0-161%
Rural Hospitals	Nueces	0-22%
Rural Hospitals	Tarrant	87-220%
Rural Hospitals	Travis	0-42%
State-Owned IMD	Bexar	0%
State-Owned IMD	Dallas	0%
State-Owned IMD	El Paso	0%
State-Owned IMD	Harris	0%
State-Owned IMD	Hidalgo	0%
State-Owned IMD	MRSA Central	0%

State-Owned IMD	MRSA Northeast	0%
State-Owned IMD	MRSA West	0%
State-Owned IMD	Travis	0%
State-Owned Non-IMD	Bexar	0%
State-Owned Non-IMD	Dallas	0-184%
State-Owned Non-IMD	Harris	0%
State-Owned Non-IMD	MRSA Northeast	0%
Urban	Bexar	0-153%
Urban	Dallas	0-647%
Urban	El Paso	0-246%
Urban	Harris	0-178%
Urban	Hidalgo	0-114%
Urban	Jefferson	0-70%
Urban	Lubbock	0-930%
Urban	MRSA Central	0-83%
Urban	MRSA Northeast	0-124%
Urban	MRSA West	0-183%
Urban	Nueces	0-116%
Urban	Tarrant	0-3596%
Urban	Travis	0-139%

i. There are 365 individual facilities that are reported as 0% for the ACIA increase. Is it correct to say that these facilities are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap? Or did these facilities not apply to participate?

State Response: There are now 166 individual facilities that are reported as 0% for ACIA. Both reasons cited above resulted in facilities being reported as 0% for ACIA.

CMS Round 2 Question: Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final provider level payment analysis, please differentiate between those facilities that are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap (e.g. 0%) vs. those facilities that did not apply for the ACIA portion (e.g. N/A).

State Round 2 Response: Column Y has been added in the "CHIRP Payment Calc" tab of Attachment C to indicate whether a facility requested participation in the ACIA component or not.

CMS Round 3 Question: In looking at tab "CHIRP Payment Calc" in Attachment C, in Column Y:

1. What does "#N/A" mean?

State Round 3 Response: This is an error that occurred because some of our providers do not yet have a TPI, an identifier that we use to index data. It is now corrected.

2. Of the 419 hospital entries, 400 hospitals requested to participate in ACIA, 16 hospitals did not request to participate, and 3 are listed as "#N/A". Is this an accurate summation?

State Round 3 Response: After the error correction, we see that 17 hospitals did not request to participate. The 402 others requested to participate in ACIA.

ii. There are 9 facilities that are reported as 0% UHRIP increase but are reported as having an ACIA rate increase. The 9 facilities are listed below. Does this mean that the rates negotiated by the plans result in no Medicare gap but there is still an ACR gap? Also, can the state confirm if the facilities still must meet the requirements for both UHRIP and ACIA?

State Response: There are now 25 facilities that have this circumstance. Yes, this usually means the rates negotiated by the plans result in no Medicare gap but there is still an ACR gap. If a provider is in this situation, it must still meet the requirements for both UHRIP and ACIA. However, the values have been updated based upon actual enrollment.

NPI	Provider Name	Class	SDA	UHRIP Rate (Component 1)	ACIA Rate (Component 2)	Total CHIRP Rate Increase
1467442418	NORTHWEST HEALTHCARE SYSTEM INC-NORTHWEST TEXAS-PSYC UNIT	Urban	Lubbock	0%	78%	78%
1447355771	SETON HEALTHCARE-DELL CHILDRENS MEDICAL CENTER	Children's	Travis	0%	188%	188%
1407191984	BSA HOSPITAL LLC-BAPTIST ST ANTHONYS HEALTH SYSTEM	Urban	Lubbock	0%	140%	140%
1437171568	METHODISTS CHILDRENS HOSPITAL-COVENANT CHILDRENS HOSPITAL	Children's	Lubbock	0%	100%	100%
1972517365	COVENANT HEALTH SYSTEM-COVENANT MEDICAL CENTER	Urban	Lubbock	0%	302%	302%

1285798918	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT-UNIVERSITY OF TEXAS SOUTHWESTERN UNIVERSITY HOSPTI	State-Owned Non-IMD	Dallas	0%	184%	184%
1770579591	FORT DUNCAN REGIONAL MEDICAL CENTER LP-FORT DUNCAN REGIONAL MEDICAL CENTER	Rural	Hidalgo	0%	60%	60%
1912948845	PHYSICIANS SURGICAL HOSPITALS LLC-QUAIL CREEK SURGICAL HOSPITAL	Urban	Lubbock	0%	410%	410%
1013941780	COVENANT LONG TERM CARE LP-COVENANT SPECIALTY HOSPITAL	Urban	Lubbock	0%	930%	930%

CMS Round 3 Question: In reviewing Attachment C, there appears to be 24 facilities that have a 0% inpatient UHRIP rate but would have an ACIA rate increase, and 4 facilities that have a 0% outpatient UHRIP rate but would have an ACIA rate. Is that an accurate summation?

State Round 3 Response: Yes, that is the state's result as well.

iii. There is also a number of SDA/class combinations where only some of the facilities would receive an ACIA increase but not all. Is this because only some of the facilities applied for the ACIA component and others did not? Is it that the other facilities did not have a remaining ACR gap after the UHRIP increase?

State Response: Both of the reasons cited above could occur, so the assumptions are correct. Please see the "Revised Q21 Hospital Rates" tab of Attachment 1 for the updated rates.

CMS Round 2 Question: Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final provider level payment analysis, please differentiate between those facilities that are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap (e.g. 0%) vs. those facilities that did not apply for the ACIA portion (e.g. N/A).

State Round 2 Response: Column Y has been added in the "CHIRP Payment Calc" tab of Attachment C to indicate whether a facility requested participation in the ACIA component or not.

Children's Hospital	Harris	1 facility reported with ACIA increase; other 3 reported 0%

Non-State-Owned IMD	Dallas	1 facility reported with ACIA increase; other 6 reported 0%
Non-State-Owned IMD	Harris	1 facility reported with ACIA increase; other 15 reported 0%
Non-State-Owned IMD	MRSA West	1 facility reported with ACIA increase; other 3 reported 0%
Non-State-Owned IMD	Travis	2 facilities reported with ACIA increase; other 5 reported 0%
Rural Hospitals	Bexar	1 facility reported with ACIA increase; other 2 reported 0%
Rural Hospitals	Hidalgo	1 facility reported with only ACIA increase; other reported no increases.
Rural Hospitals	Jefferson	2 facilities reported with ACIA increase; other 4 reported 0%
Rural Hospitals	Lubbock	2 facilities reported with ACIA increase; other 8 reported 0%
Rural Hospitals	MRSA Central	2 facilities reported with ACIA increase; other 18 reported 0%
Rural Hospitals	MRSA Northeast	13 facilities reported with ACIA increase; other 10 reported 0%
Rural Hospitals	MRSA West	15 facilities reported with ACIA increase; other 50 reported 0%
Rural Hospitals	Nueces	4 facilities reported with ACIA increase; other 2 reported 0%
Rural Hospitals	Tarrant	1 facility reported with only ACIA increase; other reported 0%.
Rural Hospitals	Travis	5 facilities reported with ACIA increase; other 1 reported 0%
State-Owned Non-IMD	Dallas	1 facility reported with only ACIA increase; other reported 0%.
Urban Hospitals	Bexar	8 facilities reported with ACIA increase; other 14 reported 0%
Urban Hospitals	Dallas	23 facilities reported with ACIA increase; other 31 reported 0%
Urban Hospitals	El Paso	5 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	Harris	10 facilities reported with ACIA increase; other 59 reported 0%
Urban Hospitals	Hidalgo	10 facilities reported with ACIA increase; other 9 reported 0%
Urban Hospitals	Jefferson	4 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	Lubbock	5 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	MRSA Central	7 facilities reported with ACIA increase; other 4 reported 0%
Urban Hospitals	MRSA Northeast	8 facilities reported with ACIA increase; other 12 reported 0%
Urban Hospitals	MRSA West	7 facilities reported with ACIA increase; other 8 reported 0%
Urban Hospitals	Nueces	3 facilities reported with ACIA increase; other 8 reported 0%
Urban Hospitals	Tarrant	20 facilities reported with ACIA increase; other 22 reported 0%
Urban Hospitals	Travis	13 facilities reported with ACIA increase; other 13 reported 0%

iv. CMS' understanding is that the facilities who apply for the ACIA program must provide commercial payer data as part of the application. What is the state's process for verifying this data?

State Response: Providers must certify that the data is accurate. Providers are responsible for keeping all documentation for a period of no less than 5 years from the date of application. Providers are subject to fraud, waste, and abuse audits. If HHSC determines at any point that rates were based upon inaccurate information the providers would be subject to recoupment and potential other legal remedies available to the state.

CMS Round 2 Question: Can the state please further explain what the providers must do to certify the accuracy of the data? Does the state do any checks on the validity of the data submitted? Does the state plan to conduct any audits of the data?

State Round 2 Response: The state does not currently plan to conduct audits specifically focused on the information provided in the CHIRP application, however, providers are subject to oversight by the state's Office of Inspector General. If at any point the state discovers that a provider misrepresented the data submitted in the CHIRP application, the provider would be subject to all possible legal and financial remedies, including recoupment of all funds.

g. Across both components, it appears that 196 facilities would receive an increase of over 100% of negotiated rates; 45 of these facilities would receive an increase of over 200% of negotiated rates. Does the state have any concerns with this level of increase? Does the state have any concerns about the underlying rates paid by the plans being insufficient to ensure access to care and network adequacy?

State Response: Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program. Based upon actual enrollment, 169 of 412 providers would receive a rate increase that exceeds 100% of negotiated rates. Sixty-six of those providers would receive a rate increase of 200% or more.

The state is proposing these rate increases as they are supported by estimates of what Medicare or average commercial payors would have paid for the same services. The state works with our managed care organizations and providers to ensure access to care and network adequacy requirements are met. With respect to access to care, the state notes that during the initial year that UHRIP was created, the stated goal was to support and improve access to care. The state reaffirms that this program will help support beneficiaries' access to care as it has for the prior four years, but with the expansion and reform of UHRIP into CHIRP, we will also target additional quality goals and objectives.

CMS Round 2 Question: How does the state work with the managed care organization and provider to ensure access to care? Would the state be able to share any data that supports the state's affirmation that this SDP (or UHRIP) has helped to support and improve access to care?

State Round 2 Response: In terms of how UHRIP has helped to support and improve access to care, the goal of UHRIP is to ensure access to care by preventing decreases in network adequacy. This is the stated evaluation hypothesis in the UHRIP evaluation report (see "Hypothesis 1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.").

The *Results* section of the UHRIP Evaluation Report 2018-2019 (CHIRP reprint Attachment J) also contains information about the state's Network Adequacy contract requirements. HHSC ensures that MCOs and DMOs have adequate provider networks and provide access to care. The state tracks timeliness of care through annual surveys; monitors member and provider complaints; monitors provider terminations; analyzes geo-mapping reports to measure the distance and travel time between providers' geographic locations and members' residences; and monitors utilization of out-of-network providers.

The results of the evaluation report show that network adequacy for acute care hospital providers was maintained over time, despite the limited study period for which we have data available.

h. In particular, there are 7 facilities that would receive a total CHIRP increase of 400+% of the negotiated rate. Can the state first confirm the information provided here for these 7 is correct and there are no typos? If this is correct, this would suggest that plans are paying these facilities at rates between 2.7 - 24.4% of Medicare. If this is the case, please explain how this rate is sufficient for the plan to maintain its access to care requirements?

State Response: The information for the seven facilities was correct at the time of the initial submission of the pre-print and was based upon the data available at the time. However, values have been updated based upon actual enrollment in the program. The state notes that the percentage increases noted below are for a total CHIRP increase and are not necessarily a comparator to Medicare. In most cases, large percentage rate increases are driven by the ACIA component, which is indicative that the commercial insurance payors are reimbursing certain providers at a much higher rate than both Medicaid and Medicare.

As CMS is aware, Texas is home to some of the most renowned providers in the world, many of whom provide specialty services for which they may have been able to negotiate with commercial payors for a substantial payment-to-charge ratio.

NPI	Provider Name	Class	SDA	UHRIP Rate (Component 1)	ACIA Rate (Component 2)	Total CHIRP Rate Increase
1649273434	BAYLOR REGIONAL MEDICAL CENTER AT PLANO-	Urban	Dallas	58%	432%	490%
1962504340	TEXAS HEART HOSPITAL OF THE SOUTHWEST LLP-BAYLOR SCOTT &	Urban	Dallas	58%	647%	705%

	WHITE THE HEART HOSPITAL PLANO					
1609855139	BAYLOR HEART AND VASCULAR CENTER	Urban	Dallas	58%	575%	633%
1912948845	PHYSICIANS SURGICAL HOSPITALS LLC-QUAIL CREEK SURGICAL HOSPITAL	Urban	Lubbock	0%	410%	410%
1013941780	COVENANT LONG TERM CARE LP-COVENANT SPECIALTY HOSPITAL	Urban	Lubbock	0%	930%	930%
1871898478	MAYHILL BEHAVIORAL HEALTH LLC-	Urban	Tarrant	89%	3596%	3684%
1841354677	Texas DSHS TCID	State-Owned Non-IMD	Bexar	2325%	0%	2325%

10. Preprint Question 23: Please provide the reimbursement rate analysis for each class in each SDA separately for the mandatory and optional payments and in total. We also request that the state provide this analysis separately for inpatient and outpatient services.

    State Response: The program values have been updated based upon actual enrollment in the program. The requested payment level demonstrations are included in Attachment 1 in the "IP UHRIP Payment Levels", "OP UHRIP Payment Levels", "IP ACIA Payment Levels", "OP ACIA Payment Levels", "IP CHIRP Payment Levels", and "OP CHIRP Payment Levels" tabs. The UHRIP tabs compare to the Medicare Upper Payment Limit, the ACIA tabs compare to the Average Commercial Reimbursement for providers expected to receive an ACIA payment, and the CHIRP tabs compare the total CHIRP payments to the Medicare UPL and ACR UPL separately and only include the providers that are expected to receive an ACIA payment. The UHRIP tabs are inclusive of all providers, but the ACIA tabs are inclusive of only those providers that have applied to participate in ACIA.

    Providers who did not apply for ACIA did not supply Texas with the necessary data to calculate an ACR estimate for their encounters. As a result, including payments to these providers in the numerator when comparing to ACR estimates in the denominator that are from a more limited set would be misleading.

    Texas can confirm that no provider who participates only in UHRIP will receive only payments that are based upon 100% of the aggregate Medicare UPL room for their respective class. Similarly, for providers who participate in ACIA, they will receive no more than ACR.

    CMS Round 2 Questions:

    1. Can the state clarify the statement "Texas can confirm that no provider who participates only in UHRIP will receive only payment that are based upon 100% of the aggregate

Medicare UPL room for their respective class." Did the state mean to say that the state can confirm that no provider who participates only in UHRIP will receive no more than the Medicare UPL for the class and SDA? **State Round 2 Response:** Yes. The state can confirm that no provider who participates only in UHRIP will receive more than the Medicare UPL for the class and SDA.

2. Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data.

11. In previous years, the state had a minimum fee schedule requirement for rural hospital inpatient and outpatient services tied to the state plan rate. While such a preprint is no longer subject to written prior approval, can the state confirm if this minimum fee schedule requirement would still be in effect for SFY 2022?

    State Response: Yes, the minimum fee schedule requirement for rural hospitals will still be in effect for SFY 2022, in accordance with state statute. As CMS knows, rural hospitals are frequently financially vulnerable, and the minimum fee schedule ensures they receive the equivalent rate to the rate they would have been paid under the state plan. The rate increases from CHIRP will be available to those who applied to incentivize quality improvements.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

12. Will the state include the UHRIP portion of the payment in the capitation rates in a manner consistent with prior years? If not, please describe the differences in the methodology this year.

    State response: Yes.

13. Please describe how the state plans to include the ACIA portion of the payment in the capitation rates in more detail.

    State response: ACIA will be included in the same way as UHRIP but using the ACIA percent increases. To the extent possible, there will be an ACIA section and capitation rate component in the rate certification, separate from UHRIP.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

General Comment: The financing of the CHIRP state directed payment appear to be financed by local units of government providing intergovernmental transfers (IGTs), funds for which are largely derived from the taxing authority of these units of government through the Local Provider Participation Fund, or LPPF. The state is attesting that the LPPF is broad-based and uniform. However, it appears that not all hospitals are being taxed under the LPPF, and it also appears that some of the units of government providing IGTs do not receive any state appropriated funds and do not have any taxing authority. The state has indicated that these units of government will be funding these through public private partnerships.

14. On CHIRP spreadsheet (Attachment E) appears to indicate that Coryell County Memorial, Decatur, Fannin County, and Uvalde County Hospital Authorities all have taxing authority, while

the QIPP spreadsheet (Attachment F-1) indicates that they do not have taxing authority. Please explain this discrepancy.

State Response: The discrepancy was an oversight and these entities should have been listed as not having taxing authority. This information has been corrected in the "Revised Q35a IGT Entities" tab of Attachment 1.

15. Related to the above, for any entities that may or may not have taxing authorities and do not receive any state appropriated funds, please describe where the funding for those IGTs will come from. We note that in some of the funding information provided under the various proposals, that some of the entities which do not have taxing authority and do not receive payments are funding a substantial IGT ($20M or more). The state has an obligation, regardless of the IGT being voluntary or compulsory, to ensure that all federal requirements related to program financing are met.

State Response: The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51.

The public entities referred to in the state's response to Question 14 do have authority to utilize other public revenue instruments. For example, Fannin County Hospital Authority was created by the county commissioner's court of Fannin County pursuant to Chapter 264, Texas Health and Safety Code. Fannin County Hospital Authority does not have taxing authority but does have authority to utilize other public revenue instruments, such as bonds, to support their public activities. The funds transferred to the state by Fannin County are public funds.

Similarly, Decatur County Hospital Authority was created by the county commissioner's court of Decatur County pursuant to Chapter 262, Texas Health and Safety Code. Decatur County Hospital Authority does not have taxing authority but does have authority to utilize other public revenue instruments, such as bonds, to support their public activities. The funds transferred to the state by Decatur County are public funds.

CMS Round 2 Response: As affirmed in response to question 14, it is the state's responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51. The ability of a unit of government to issue bonds is typically defined by the government entity's authorizing statute. We are assuming that this is the case with the hospital districts involved in this arrangement. The statute indicates that CMS "may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section." To the extent that bonds are neither state or local taxes, the state has an obligation to ensure that the transferred funds are not "derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share" as indicated in the statute. Please note, that CMS is researching this matter further and may have additional questions for the state.

1. CMS has concerns that to the extent that the providers or provider-related organizations are participating in the purchasing of municipal bonds, that such participation could provide the appearance of a provider-related donation, potentially requiring the state to offset the collected value of the donation from the claim for FFP. Further, the notion that bonds can be thought of as loans that investors make to local governments, then the repayment of the bonds to any provider or provider-related organization may provide the appearance of recycling. The state is obligated to ensure these funding mechanisms are consistent with the statute and implementing regulations throughout the operations of such payment programs. Has the state considered how it intends to oversee the sources of financing that will support payments under this proposal to ensure the arrangements do not now and in the future entail non bona fide provider related donations or recycling of federal funds?

State Round 2 Response: HHSC is not aware of any circumstances in which a provider or provider-related organization has participated in the purchasing of municipal bonds.

CMS Round 3 Questions:

1. Can the state affirm that there are no providers that are investing in municipal bonds that are the source of the IGT that funds this state-directed payment?

   State Round 3 Response: The state has no information regarding the sale of municipal bonds by units of government, including the identities of purchasers of such bonds or whether those purchasers are providers participating in CHIRP.

2. Can the state please describe what safeguards are in place to ensure that providers are not investing in municipal bonds that are the source of the IGT that funds this state-directed payment back to the provider, a related entity to the provider, or other providers in the same provider class in a manner that would result in a non-bona fide provider-related donation as described by 42 CFR § 433.54?

   State Round 3 Response: The state will notify local governmental entities of this potential concern. Additionally, the state is currently working to implement a local funds monitoring effort and will incorporate this into the risk assessment questions that that are planned as part of that effort.

2. Please affirm the understanding that approval of this funding mechanism by CMS to serve as the non-federal share would not protect the state from financial risk should the arrangements result in non-bona fide provider related donations or a recycling mechanism as our review is predicated on the issued bonds as a normal course of business and not as a means to circumvent federal financing requirements.

State Round 2 Response: HHSC affirms this understanding.

16. Please affirm that no payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

State Response: Texas affirms that payments are not made under a hold harmless provision or practice.

17. Are there any agreements, written or otherwise, regarding the LPFF among providers, counties, the state, and/or any other entities that are designed to hold taxpayers harmless for the cost of the tax as defined by 42 CFR § 433.68 (f) so that taxpayers that pay more in tax than they receive in payments are guaranteed directly or indirectly to be made whole?

    State Response: Texas affirms that neither the state nor any unit of government imposing a mandatory payment has entered into an agreement, written or otherwise, providing for any direct or indirect guarantee to hold a provider harmless for all or any portion of a mandatory payment amount.

    CMS Round 2 Question: Is the state aware of any agreements between or among providers designed to hold taxpayers harmless for the cost of the tax? If such agreements exist, what is the state's involvement with and policy towards them?

    State Round 2 Response: The state has been told that some sorts of arrangements between private entities exist. The state seeks no involvement and has not been involved in any such arrangements. The state does not regulate such private arrangements because it does not have the authority to do so. HHSC is willing to discuss with CMS what form of monitoring could occur to ensure that local government involvement in these arrangements does not occur.

    CMS Round 3 Response: CMS continues to have some concerns with the financing of the non-federal share as it relates to the LPPF. We are still evaluating the state's responses and may have additional follow-up questions at a later date.

18. Given the fact that not all hospitals are being taxed under the LPPF, how can the State say that the tax is broad-based under Sections 1903(w)(3)(B) and 32 CFR § 433.68 (c) so that the tax is imposed on all non-federal non-public providers in the permissible class located at 42 CFR § 433.56?

    State Response: Texas does not have a state-wide health care-related tax. Certain units of local government in the state, pursuant to authorization from the Texas legislature, have implemented mandatory payments that are made to the unit of government's LPPF by all non-federal, non-public providers in the area over which the unit of government has jurisdiction, in accordance with 42 CFR 433.68(c)(2).

19. In item #12 of the CHIRP Enrollment application, the language says: *"By checking this box, I certify, as the entity that owns the hospital, that no part of any payment made under CHIRP will be used to pay a contingent fee and that the agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds."* Please elaborate on what is intended by the inclusion of this statement.

State Response: The state has a similar requirement in its Medicaid provider enrollment agreement. Because the state is requiring information about commercial payments and charges for which the state could not obtain the data independently, we included this statement to remind providers of their responsibility under the terms of the Medicaid enrollment agreement related to third party billing entities, as we believe that this is applicable also to an application preparer or the provider in this context.

20. The CHIRP Enrollment application seems to suggest that the city/county/hospital district can choose which hospitals/types of hospitals can benefit from the IGT/supplemental payments. Item #14 in the list says: "*As a sponsoring governmental entity, which class or classes of hospitals do you wish to support through IGTs of public funds? This information will be used to calculate suggested IGT responsibilities*." The form proceeds to list out various types of hospitals classes. Section 1902(a)(2) of the Act says that the state plan must provide " for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan." If a government entity limits which providers may benefit from an IGT, how does the state assure that any hospitals that qualify under the CHIRP program will have their underlying payments fully funded as proposed under the CHIRP program?

    State Response: Texas distributes a suggested list of IGT amounts to governmental entities. In our Service Delivery Areas, we may have several governmental entities that wish to transfer IGT, and this helps us to apportion the suggestions. However, the suggestions are non-binding, and local governments may transfer whatever amount they wish at the time that IGT is collected. When IGT is collected, it is pooled for all classes in the service delivery area. Governmental entities do not limit which providers may benefit from an IGT.

21. Please describe the timing associated with the city/county/hospital district filing the CHIRP application the subsequent finalization of the associated contracts. Section 1902(a)(2) of the Social Security Act obligates the state to pay that amount regardless of the amount of IGT or other non-federal share received from other sources. Please describe what occurs in instances where the funds derived from the cities/counties/hospital districts are less than the amount the state is obligated to pay out under the approved contracts. Conversely, please describe what occurs when the funds derived from the cities/counties/hospital districts are in excess of the amount the state is obligated to pay out under the approved contracts.

    State Response: The state enrolls providers in April and works to review all applications before May 1. The governmental entities typically transfer IGT in early June, but the state usually does not finalize Medicaid managed care contracts until mid-July due to the complexity of the contracting process. If the state has less IGT than the amount needed to pay the increased capitation rates that are in the approved contracts, we would be required to use state General Revenue unless local governments voluntarily transfer additional IGT to the state. If there is excess IGT collected, the state returns the unused IGT proportionally to local governments

based upon the way it was received and without respect to the amount that any provider was paid under the program. The reconciliation process typically occurs following the run-out period for member month adjustments that occurs in the two years following the program period.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

22. Preprint Question 42: Please confirm that the objectives listed in the preprint also appear in the updated quality strategy.

State Response: HHSC expects CHIRP to advance DSRIP transition plan focus areas that have been incorporated into the strategy on pages 36 and 37, including primary care, health promotion and disease management, behavioral health, care coordination, and maternal health and birth outcomes.

In 2017, HHSC developed an *HHS Healthcare Quality Plan* (link) to provide a higher level view of the priorities for the Medicaid program as required by state law. The 2017 Quality Plan featured a table of goals (labeled "Priorities") and related objectives (labeled "Desired Outcomes") (Quality Plan, page 13). HHSC updated the goals and objectives from the 2017 Quality Plan and incorporated the goals into the 2021 Texas Managed Care Quality Strategy. Please see Attachment 3 for the updated goals and objectives.

HHSC expects to achieve these objectives over time through its current and future initiatives linked to each quality goal. Appendix C of the Quality Strategy is a matrix that maps how each current HHSC quality initiative, report, and EQRO activity aligns with and works toward achieving HHSC's quality goals.

The CHIRP objectives submitted in the preprint (in response to question 42) were derived from the updated objectives from the Quality Plan. HHSC submits the following table as a revised response to Question 42, Table 7, of the preprint.

In addition, HHSC has updated the Evaluation Plan (see Attachment 2) to align the evaluation questions and hypotheses with the revised objectives.

[Preprint Question 42] Table 7 – Payment Arrangement Quality Strategy Goals and Objectives

Quality Goal	Objective
a. **Promoting optimal health for Texans** at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health	Individuals practicing healthy behaviors yield reduced rates of tobacco use, obesity, and substance use
b. **Providing the right care in the right place at the right time to ensure people can easily navigate the health system** to receive	Reduced rate of avoidable hospital admissions and readmissions

timely services in the least intensive or restrictive setting appropriate	
c. **Keeping patients free from harm** by building a safer healthcare system that limits human error	Reduced rate of avoidable complications or adverse healthcare events in all care settings
d. **Promoting effective practices for people with chronic, complex and serious conditions** to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs	Reduced rate of avoidable hospital and emergency department visits for individuals with medical complexity, including with co-occurring behavioral health diagnoses
e. **Attracting and retaining high-performing Medicaid providers and other healthcare professionals** to participate in team based, collaborative, and coordinated care	Providers participate in learning collaboratives, sharing and applying best practices to deliver high-value care
	Reduced proportion of population reporting difficulties accessing care
	Timely and efficient exchange of health information and increased interoperability

23. Preprint Question 43:
    a. The state notes in Attachment H, "UHRIP includes two structure measures applicable to all participating hospitals and requires twice-yearly submission of status updates for all measures." Later in the attachment, the state says, "Hospitals are not required to implement structure measures as a condition of reporting or program participation." Can the state please clarify this distinction?

       State Response: "Structure Measures" are a type of measure (as opposed to "Process Measures" and "Clinical Outcome Measures") that help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For UHRIP, hospitals are required to report on structure measures as a condition of participation. At this time, there are not prescribed implementation or achievement requirements tied to a structure measure. Reporting on structure measures will primarily be formatted as multiple-choice selections with some qualitative questions.

    b. With respect to the UHRIP measures, we request Texas designate more concrete performance targets for each measure, using numeric percentage increases or decreases to identify the state's actual target for the measures that would achieve the SDP's goals and objectives. For measures that do not have a national benchmark such as the PPC and PPA measures, we request the state define a specific performance target other than "maintain or decrease annually".

It is important to acknowledge that while HHSC is committed to developing a meaningful evaluation of the success of the program, the state does anticipate that the public health emergency's impact on utilization and quality data could make year-on-year comparisons difficult or unreliable in the future.

c. For the two UHRIP structural measures, to what extent are hospitals to-date satisfying these measures?

State Response: Structure Measure 1-HIE participation: According to the Texas Health Services Authority (THSA), there are approximately 750 hospitals in Texas and 446 hospitals in Texas are in Health Information Exchanges (59.5%). Of the 446, 244 of the hospitals participate in a regional HIE; of those hospitals 144 are in national HIEs (Carequality, Commonwell and the eHealth Exchange) as well. Another 202 hospitals are in national HIEs but not involved in a Regional HIE.

Structure Measure 2-SDA Learning Collaborative participation: Participation in regional learning collaboratives (hosted by Regional Healthcare Partnership (RHP) anchor entities) has been a requirement for DSRIP performing providers, but learning collaboratives by service delivery area (SDA) will be new collaboratives. Therefore, hospitals that were DSRIP performing providers were satisfying a similar measure in order to receive DSRIP payments, but no hospitals have been measured using this new measure.

d. It appears that non-state owned IMDs, state-owned IMDs and rural hospitals are not eligible for several of the ACIA modules. Is that due to minimal volume from these participating hospitals, or are there other reasons why these hospital classes are not eligible for many of the ACIA modules?

State Response: The non-state owned IMDs, state-owned IMDs, and rural hospitals are eligible for one ACIA module due to both minimum volume requirements and due to the types of services these hospitals provide. The design of the ACIA modules considered the variation among the provider classes in volume of population served, population mix served, and the types of services provided by the hospital class.

The evaluation plan includes an outcome measure specific to services provided at IMDs, Follow-up after Hospitalization for Mental Illness. So, while the provider-reported data for IMDs only includes one structure measure, the structure measure is related to the outcome measure HHSC will be tracking in the evaluation. The provider-reported process measures in the rural component are measures that will be tracked through the evaluation as well.

e. It also appears that hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA and no reporting will be required. Is this correct? If so, can the state explain its rationale for this and estimate how many

hospitals would be eligible for ACIA and not be required to report on any ACIA measures?

State Response: Texas identified provider-reported measures for evaluation purposes that align with the Quality Strategy. Because CHIRP is open to all hospitals in Texas that serve people enrolled in Medicaid managed care, HHSC cannot ensure that every eligible hospital participating in ACIA provide services that meet measure specification inclusion criteria. For example, there are a very small number of day surgery hospitals eligible to enroll in CHIRP that may not provide inpatient services that are measured as part of the Hospital Safety module. Texas does not currently know how many hospitals, if any, would not have any required reporting but expects the number to be very small.

f. In the application, it states that for adult and pediatric hospital and safety outcome measures, hospitals will report a performance rate as specified for all-payer types, but that for all other outcome and process measures, hospitals must report performance rates stratified by Medicaid, uninsured and other payer-types. However, the ACIA Hospital Safety and ACIA Pediatric program components contain several different measures (C2-106 – C2-110 for ACIA Hospital Safety and C2-111 – C2-116). Please explain both what this means and why the adult and pediatric hospitals safety outcomes measures will not be stratified.

State Response:

C2 - ACIA Hospital Safety

- C2-106: Hospital Safety Collaborative Participation
- C2-107: Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
- C2-108: Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure
- C2-109: Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
- C2-110: Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

In the C2 – ACIA Hospital Safety module, there are a total of five quality measures, listed above, including one Structure Measure and four Outcome Measures. The one Structure Measure (C2-106) does not require reporting by any payer type stratification, but requires only complete reporting on the provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. The four Outcome Measures in this module (, C2-107, C2-108, C2-109, and C2-110) are specifically reported per measure steward measure specifications as hospital safety standardized infection ratios (SIR), which are not stratified by payer types.

The Standard Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare associated infections (HAIs), including catheter-associated urinary tract infections (CAUTI) (C2-107), central line-associated bloodstream infections (CLABSI) (C2-108), Clostridioides difficile

infections (CDI) (C2-109), and surgical site infections (SSI) (C2-110). In HAI data analysis, the SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population (i.e., NHSN baseline), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence (various facility and/or patient-level factors that contribute to HAI risk within each facility).

Therefore, for measures C2-106 through C2-110, the reported denominator is the predicted NHSN baseline for a given HAI (which is not stratified by payer type) and the reported numerator is the provider's actual observed number of given HAIs, such that the resulting calculation is reported as the SIR.

C2 - ACIA Pediatric

- C2-111: Hospital Safety Collaborative Participation
- C2-112: Pediatric Adverse Drug Events
- C2-113: Pediatric CLABSI
- C2-114: Pediatric CAUTI
- C2-115: Pediatric SSI
- C2-116: Engagement in Integrated Behavioral Health

In the C2 – ACIA Pediatric module, there are a total of six quality measures, including one Structure Measure, four Outcome Measures, and one Process Measure. The one Process Measure (C2-116) is reported by payer type stratification. However, the one Structure Measure (C2-111) does not require reporting by any payer type stratification and requires complete reporting on the provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. The four Outcome Measures in this module (C2-112, C2-113, C2-114, and C2-115) are specifically reported as pediatric hospital safety infection rates, and per the measure steward measure specifications, these pediatric infection rates are reported by 1000 patient days, which are not stratified by payer types.

24. Preprint Question 44:
    a. With respect to limitations to the evaluation, the state noted that "Collectively, these limitations suggest the evaluation does not have a high degree of sensitivity to detect direct outcomes associated with UHRIP. Additional data collection efforts, such as provider-reported information or investigations into the cost-effectiveness of UHRIP payments, may provide greater opportunities to examine the direct impacts of UHRIP." Please explain how the state be including these other methods going forward to improve the validity of results.

State Response: Years 1 -4 of the UHRIP program did not include any provider specific reporting. In addition, program years 1 – 4 employed an opt-out enrollment process. Year 5 of CHIRP employs an opt-in enrollment, allowing HHSC to better isolate hospitals that participate in UHRIP and specific ACIA modules. Additionally, in the evaluation plan

for program year 5, Texas has proposed including the results of hospital specific reporting on identified structure, process, and outcome measures that align with the state's updated Quality Strategy. Where feasible, HHSC will also work with the EQRO to develop an ACIA specific attribution population which will allow the evaluation to look at trends across the state, as well as trends specific to Medicaid managed care members who had one or more encounters with an ACIA participating provider during the measurement year. HHSC will continue to explore methods of investigating the cost-effectiveness of UHRIP and ACIA as an intervention, but does not currently have a proposal to evaluate cost-effectiveness. Texas is open to CMS suggestions for methodologies to evaluate cost-effectiveness using existing managed care data and the currently proposed hospital specific reporting.

b. Can TX confirm that the prior year results and the evaluation plan are assessing the specific impact of this particular payment arrangement (as opposed to, say, the entirety of the state's 1115 demo)?

State Response: It is difficult to assess the specific impact of UHRIP for three main reasons: 1) Hospitals in UHRIP participated in other programs (e.g., the UC pool), and impacts of different initiatives cannot be separated; 2) UHRIP did not require any provider-reported measures, so the evaluation leveraged data produced through the EQRO for Medicaid managed care monitoring purposes. These data were not developed with UHRIP in mind, and therefore are not specifically targeted to hospital clients (e.g., CAHPS). Moving forward, the CHIRP evaluation will include provider-level reporting, which will enable the evaluation to focus more specifically on CHIRP-related measures. However, it will still be difficult to isolate the effect of CHIRP from the other initiatives simultaneously implemented across the state; 3) Because UHRIP enrollment was structured as an opt-out program and all eligible hospitals within an SDA participated, there is not an available comparison group to isolate the performance of UHIRP hospitals as compared to non-UHRIP hospitals.

c. The CHIRP Evaluation Plan (Attachment I) indicates that, *"The primary unit of analysis for CHIRP evaluation measures will be the Medicaid member and the CHIRP evaluation population will consist of all STAR and STAR+PLUS members, including those members who may not have had an encounter with a CHIRP hospital during the study timeframe."* Why is the evaluation including members without a CHIRP hospital encounter?

State Response: Medicaid member-level data and CAHPS® Survey data (data sources for Evaluation Questions 2 and 4) are taken from EQRO reports. CAHPS Survey data and some Medicaid member-level data like PPAs measured by the EQRO cannot be attributed to an encounter with a CHIRP provider.

d. Under the "Anticipated Limitations" section in the CHIRP Evaluation Plan (Attachment I), the state says, *"The most salient threat to the internal validity of the evaluation is the possibility that factors external to the CHIRP program will influence the evaluation*

measures. For example, several additional directed payment programs (e.g., the Comprehensive Hospital Increase Reimbursement Program and Rural Access to Primary and Preventive Services) will be implemented at the same time as CHIRP". For the underlined, did the state intend to reference the TIPPS program, and not CHIRP?

State Response: Yes, the reference to CHIRP was a typo. It should read TIPPS, not CHIRP. This change is reflected in Attachment 2.

e. In the CHIRP Evaluation Plan (Attachment I), can the state please clarify if all measures that will be collected for the ACIA modules are captured in the evaluation plan?

State Response: No, providers will submit data for some measures that will not be included in the evaluation plan. However, all measures in the ACIA modules relate to the evaluation plan measures. See table below.

CHIRP Measure ID	CHIRP Program Measure Name	Evaluation Measure Name
C2-103	AIM Collaborative Participation	Pregnancy Associated Outcome Measure: Severe Maternal Morbidity (SMM Among All Deliveries) * Cesarean Sections among uncomplicated deliveries (IQI 21)
C2-104	Severe Maternal Morbidity	Pregnancy Associated Outcome Measure: Severe Maternal Morbidity (SMM Among All Deliveries) * Potentially Preventable Complications (PPC)*
C2-105	PC-02 Cesarean Section	Cesarean Sections among uncomplicated deliveries (IQI 21)
C2-106	Hospital Safety Collaborative Participation	Potentially Preventable Complications (PPC)*
C2-107	Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-108	Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-109	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-110	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-111	Hospital Safety Collaborative Participation	Potentially Preventable Complications (PPC)*
C2-112	Pediatric Adverse Drug Events	Potentially Preventable Complications (PPC)*
C2-113	Pediatric CLABSI	Potentially Preventable Complications (PPC)*
C2-114	Pediatric CAUTI	Potentially Preventable Complications (PPC)*
C2-115	Pediatric SSI	Potentially Preventable Complications (PPC)*
C2-116	Engagement in Integrated Behavioral Health	Follow-Up After ED Visits for Mental Illness (FUM)
C2-117	Written transition procedures that include formal MCO relationship or	Follow-Up After Hospitalization for Mental Illness (FUH)*

	EDEN notification/ADT Feed for psychiatric patients	Potentially Preventable Readmissions (PPR)
C2-118	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for non-psychiatric patients	Potentially Preventable Readmissions (PPR)
C2-119	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
C2-120	Preventive Care and Screening: Influenza Immunization	Preventive Care and Screening: Influenza Immunization

*signifies measures that will be evaluated across other proposed DPPs

f. Regarding the state's evaluation findings from previous years of the UHRIP program, we have the following comments for each of the metrics identified in Attachment J, the UHRIP evaluation report:

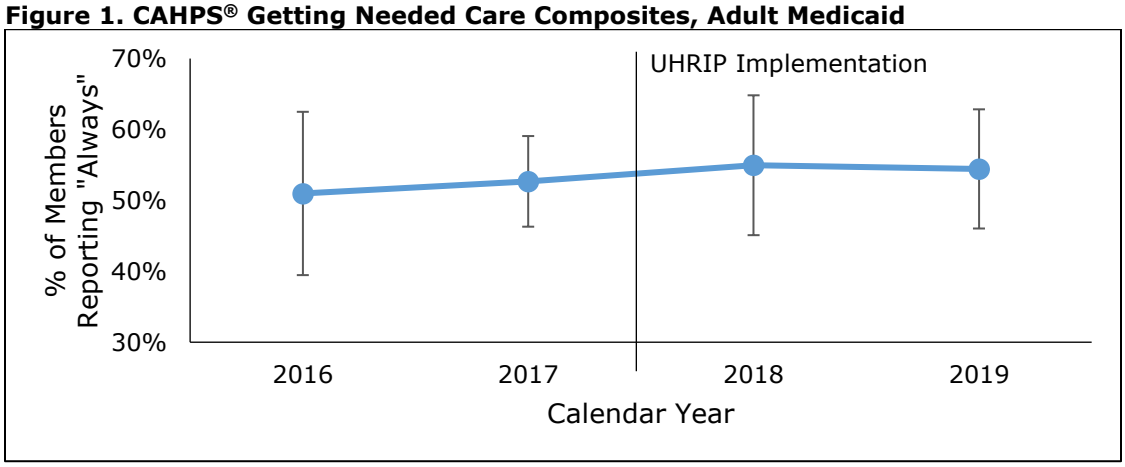
Measure Name	Performance Target*	CMCS Comment for state
CAHPS® Health Plan Survey : **Getting Needed Care - Adults**	• Exceed the U.S. average every year. • Maintain or increase TX rate annually.	Please explain how the state will address the decline in rates in 2019. State Response: The CAHPS® Health Plan survey estimates are derived from random samples of Medicaid members. Accordingly, differences in rates over time may reflect random variation in annual samples, rather than meaningful differences in the population. The 95% confidence intervals (Figure 1 shown below) indicate that the 2019 estimate is not statistically different from the 2018 estimate (i.e., the confidence intervals overlap).
CAHPS® Health Plan Survey: **Getting Needed Care - Children**		Please choose a performance target that is above the baseline rate (the baseline rate was 9% above the national benchmark in pre-implementation period). For this measure, please note in subsequent evaluations whether the outcomes met this performance target. State Response: See performance targets in the revised Evaluation Plan (Attachment 2).
CAHPS® Health Plan Survey: **Getting Care Quickly - Adults**	• Exceed the U.S. average every year. • Maintain or increase TX rate annually.	Please explain how the state will address the decline in rates between the pre- and post-implementation periods. State Response: The CAHPS® Health Plan survey estimates are derived from random samples of

		Medicaid members. Accordingly, differences in rates over time may reflect random variation in annual samples, rather than meaningful differences in the population. The 95% confidence intervals (Figure 2 shown below) indicate that the post-implementation estimates are not statistically different than the pre-implementation estimates (i.e., the confidence intervals overlap).
CAHPS® Health Plan Survey: **Getting Care Quickly - Children**		We noticed that the national benchmark was only 1% above the 2016 pre-implementation period rate and was below the 2017 rate. Please choose a performance target that is specific to the state and reflects the states goals and objectives around this metric. State Response: See performance targets in the revised Evaluation Plan (Attachment 2).
3M Potentially Preventable Admissions – STAR MCO	Maintain or decrease rate annually.	It is encouraging to see the decline in PPA but we request the state designate a specific performance target for this measures. State Response: See performance targets in the revised Evaluation Plan (Attachment 2).
3M Potentially Preventable Admissions – STAR+PLUS MCO Measure	Maintain or decrease rate annually.	Please explain what the state is doing to address the rise in PPA~~C~~s relative to baseline. State Response: PPAs are included in the CHIRP evaluation to monitor against potential negative impacts on preventable admissions. In addition to adding structure measures of care coordination practices, and preventive care measures for rural hospitals, Texas has proposed additional directed payment programs aimed at reducing the rate of PPAs through primary and preventive care.
3M Potentially Preventable Complications – STAR MCO Measure	Maintain or decrease rate annually.	Please explain what the state is doing to address the rise in PPCs relative to baseline. State Response: Texas has added specific hospital safety reporting requirements to the ACIA module of the CHIRP program, including measures related

		to C.DIFF, sepsis, and obstetric complications which are among the leading causes of PPCs in the STAR population, as well as structure measures related to the participation in learning collaboratives that address hospital practices surrounding patient safety. HHSC provides strong incentives for both MCOs and hospitals to reduce potentially preventable events (PPEs). HHSC administers the Hospital Quality Based Payment (HQBP) Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC). Hospitals can experience reductions to their payments for inpatient stays, (including their UHRIP rate enhancement payments): up to two percent for high rates of PPRs and 2.5 percent for PPCs.
3M Potentially Preventable Complications – STAR+PLUS MCO Measure	Maintain or decrease rate annually.	Please identify a performance target that demonstrates improvement based on the intervention. State Response: See performance targets in the revised Evaluation Plan (Attachment 2).

* As noted by the state on May 20, 2020 in 438.6(c) Attachment D Proposal D – UHRIP state response 20-21.

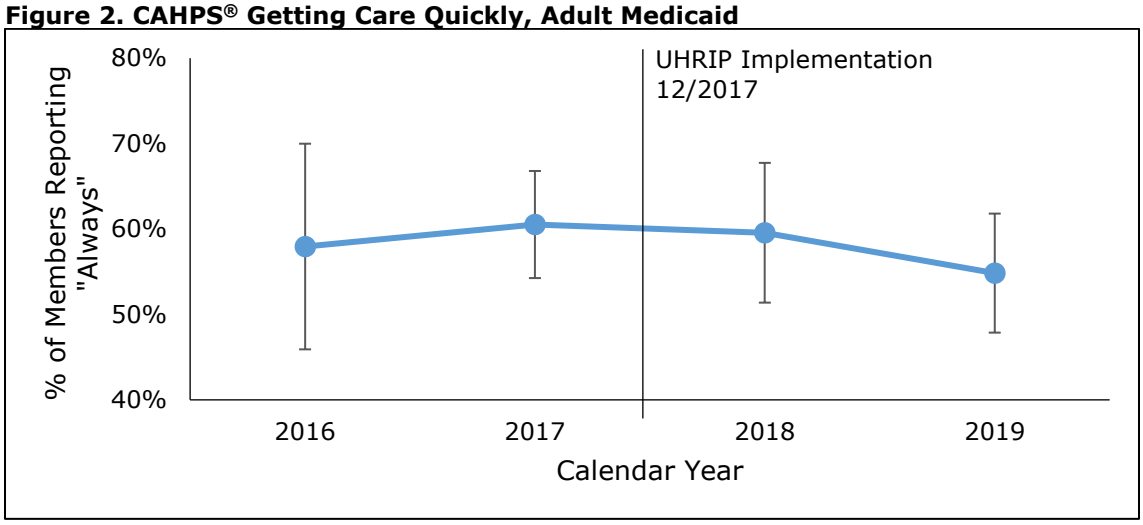
Figure 1. CAHPS® Getting Needed Care Composites, Adult Medicaid



Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded.

Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

Figure 2. CAHPS® Getting Care Quickly, Adult Medicaid



Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded.
Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.
Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

CMS Round 2 Questions:

1. Performance Targets:
   For the PPA measure, the performance target for STAR is not an improvement target. Additionally, it appears the performance target for STAR+ is close (0.02) to the baseline. Please provide an explanation for how/why these targets were chosen.

Measure Name	NQF#	Measure Steward	Baseline Statistic STAR	Baseline Statistic STAR+PLUS	Performance Target
Potentially Preventable Admissions (PPA)*	NA	3M	2017: 0.31 weights per 1,000 member months	2017: 9.32 weights per 1,000 member months	• Targets: ○ STAR 2022: 0.31 ○ STAR+PLUS 2022: 9.30

State Round 2 Response: The goal is to maintain the baseline rate. PPAs are included to help ensure that enhanced hospital payment is not associated with increased inpatient care volume.

In the UHRIP Evaluation Report (2018 – 2019) submitted with the preprint as Attachment J, HHSC explains:

"In the Texas Medicaid program, minimizing PPAs is considered primarily an MCO responsibility to be accomplished through improved access and quality with regard to outpatient care and service coordination for their members. Therefore, the PPA rate measure serves only as a sentinel, not as an indication of participating hospitals' performance. It would be an unintended consequence if this program resulted in a sharp increase in the PPA rate."

For the Getting Care Quickly measure, the adult performance target appears to be the same as the baseline. Additionally, the child performance target does not seem to be a clinically meaningful improvement. Please provide an explanation for how/why these targets were chosen.

Measure Name	NQF#	Measure Steward	Baseline Statistic STAR	Baseline Statistic STAR+PLUS	Performance Target
Getting Care Quickly*	NA	NCQA	Medicaid Adult 2017: 60.5% Medicaid Child 2017: 82.9%		• Targets: ○ Adult 2022: 60.5% ○ Child 2022: 83.0%

State Round 2 Response: The state target is to maintain or increase annually the percentage of Medicaid beneficiaries who reported getting care quickly relative to national trends (see original preprint Attachment I, Evaluation Plan). State performance has equaled or exceeded the national rate every year, except the adult rate in 2019. The HHSC target by 2022 is to return to, at least, the baseline rates. This approach recognizes that the potential impact of COVID-19 on this measure is not yet known.

2. Evaluation Population:
The state indicates in Attachment 2 that:

"The primary unit of analysis for CHIRP evaluation measures will be the Medicaid member and the CHIRP evaluation population will consist of all STAR and STAR+PLUS members, including those members who may not have had an encounter with a CHIRP hospital during the study timeframe.."

Will the hospital-level data that will be reported be limited to STAR and STAR+PLUS managed care members?

State Round 2 Response: The hospital-level data that will be reported are not limited to STAR and STAR+PLUS managed care members. Hospital-reported performance rates for outcome and process measures are stratified by Medicaid (including FFS and Medicaid managed care)

because some participating providers indicated there are challenges in the connectivity of their Electronic Health Record systems and claims/billing systems to stratify by managed care only for calendar year 2021. Moreover, as clarified in Question 23.f. above, for certain hospital safety outcome measures, hospitals will specifically report performance rates by all-payer type.

"Where feasible, the CHIRP evaluation measures will also use provider-reported data for analysis at the hospital level to supplement MMC member data."

Please confirm whether this hospital-level data is limited to Medicaid managed care members?

State Round 2 Response: The hospital-level data that will be reported are not limited to STAR and STAR+PLUS managed care members. Hospital-reported performance rates for outcome and process measures are stratified by Medicaid (including FFS and Medicaid managed care) because some participating providers indicated there are challenges in the connectivity of their Electronic Health Record systems and claims/billing systems to stratify by managed care only for calendar year 2021. Moreover, as clarified in Question 23.f. above, for certain hospital safety outcome measures, hospitals will specifically report performance rates by all-payer type.

CMS Rnd 3 Response: We continue to have concerns about the state's evaluation data. We are continuing to evaluate the state's responses and may have additional questions at a later date.

3. Evaluation Findings:
When the state submits its next preprint with the evaluation findings, please include additional context on the state's payment and QI initiatives. The state acknowledges that they cannot isolate the impact of this SDP versus other SDPs, 1115 waiver programs, and QI programs in the state. Since other programs could be impacting the evaluation results, we would like to see a more complete policy picture to better understand the data.

State Round 2 Response: The state will include narrative information on other Directed Payment Programs and Quality Improvement initiatives in the evaluation findings submitted with the next preprint.